So -- because March 26th is the date of this report. So that's a pretty big stretch. Can you narrow it down at all? If you can't, fine, but if you can --

A. No, I cannot.

Q. So sometime between the first and the second report, you were called and asked to do this second supplemental report?

A. Correct.

Q. Let's go over it. First, I want to ask you something that is mentioned in your record that's not mentioned in either report, "iliotibial band syndrome"?

A. Yes.

Q. Okay. You definitely diagnosed her with that in your record; is that correct?

A. Yes. Well, I think we had two working diagnoses at that point. I thought maybe she tore a

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medial meniscus. She was definitely tender over that lateral part of her knee.

There's two things in the lateral part of your knee that can cause popping and pain. The more common one is the illiotibial band friction syndrome. The less common one is the proximal tibiofibular instability.

So, usually, in the medical profession, you always try to put the common things first, and, occasionally, it can be something more unusual like a proximal tibiofibular problem. But after getting the MRI, we found the only area where she had extra fluid was actually the tibiofibular joint, so then I didn't think that -- and then also I gave her an injection,

and that really didn't help too much. Usually, the iliotibial friction band syndrome is at least alleviated for some time with a shot.

Q. So was it the MRI or the cortisone? Which one was it that made you determine that she didn't have iliotibial band syndrome?

A. Both of them together.

Q. So would you say, shortly after you did the MRI, then, you felt that she did not have iliotibial band syndrome?

A. I think after we gave her the injection and

the MRI.

Q. So in your estimation, even though that's mentioned in your record, then, that was just a differential diagnosis? She actually does have, then, the instability is what your final diagnosis is?

A. Yes.

Q. So that's how you came to the diagnosis, is through that testing.

What else can cause -- what can cause instability -- this instability that you've diagnosed her with?

A. Congenital problems are possible. But she doesn't have any history of congenital problems. The only real thing is trauma, some type of trauma to that knee.

Q. So falling on the knee?

A. Twisting the knee, falling on it.

Q. Okay. Can stepping off of a curb cause it?

A. It's possible depending on how rapidly you

step off it, your body weight, et cetera, the strength -- you know, some people's ligaments are a little bit looser than others.

Q. And what other types of trauma have you seen cause this instability?

A. I think that's about it.

Q. Okay.

A. Just a blow to the knee or a bad ankle sprain that's called -- an extremely high ankle sprain where it goes -- a maisonneuve fracture is what they call it.

Q. And in this instance, what trauma is it that caused the instability?

A. I can't say for sure, but it's something -- as per her history -- because the only trauma that she related was that X-ray machine, I would say it is that.

Q. But she also related she stepped off of a curb not too long after that. Could it have been caused when she stepped off of the curb?

A. No, because she had the knee problem prior to that.

Q. Did you see anything in the medical record prior to that that she complained of knee pain?

A. No. I meant my record.

Q. I'm talking about when she stepped off of a curb in 2002, in November of 2002. Could it have occurred then?

A. Could have.

Q. So that could have been a cause, then, of the instability in the knee; is that correct?

A. Depending on the mechanism of what happened

after she stepped off. If she just stepped off and

twisted her ankle not as badly as before, then no. It just depends on the degree of twisting to the ankle.

Q. So how did you decide that the instability was caused by the incident at the hospital rather than when she stepped off of the curb?

A. Because I think, in my second note, she mentioned that she had that knee problem since the first injury.

Q. Okay. But did you see anything in the medical record where she had complained of knee pain --

A. No, I did not.

Q. Okay. Now, you talk about the RSD associated with the nerve. Then you discuss the peroneal nerve palsy?

A. Correct.

Q. Are you relating that to the incident at the hospital, the peroneal nerve palsy, the foot drop?

A. Which incident?

Q. The reason why we're here today, the portable X-ray machine --

A. Yes. Well, I think the portable X-ray machine didn't cause the nerve palsy. That occurred later on from swelling and subsequent treatment. I'm not sure exactly where that nerve palsy stemmed from, but it was either -- occurred as a result of her course

of treatment.

Q. Okay. So do you know, for example, when she was casted in November -- you remember she was

casted --

A. Yes.

Q. Do you know whether the cast was padded properly behind the fibula when she was casted in the early stages?

A. I don't know anything about that.

Q. So you don't know if the cast, perhaps, was too tight and could have caused the peroneal nerve palsy?

A. No, I do not. Although Dr. -- those notes, I think -- Dr. DiPretoro, I think, at each visit, he mentioned how she was doing. So I think, if we reviewed those, you could figure out if she developed something at that point or if he made any comment about the cast being too tight or anything like that.

Q. You've been practicing three years. Have you ever had a patient with a tight cast that didn't complain about it?

A. Tight cast? I haven't had any patients that I've had to recast in the last three years.

Q. Okay. But have you ever had a patient that had a tight cast that maybe didn't complain about it?

A. Didn't complain about it? I would never know because they didn't complain about it, I guess.

Q. That's true. But when they came in, you would know that the cast was tight. You've never had anybody come in with a tight cast?

A. No. I always put them on a little bit loose.

Q. How do you know that this one wasn't tight?

A. I do not know that.

Q. So do you know, then, that the serial casting did not cause the peroneal nerve palsy?
A. I do not know that.
Q. So can you rule that out as a cause of the peroneal nerve palsy?
MR. LEVIN: Rule what out? Objection.
MS. MASSARO: The serial casting.
THE WITNESS: I cannot rule it out.
Q. (By Ms. Massaro) Okay. So could it possibly have been a proximate cause of the peroneal nerve palsy?
MR. LEVIN: Objection.
Q. (By Ms. Massaro) You can answer.
A. Could have been.
Q. I need you to explain this sentence to me: "RSD resulted from initial soft-tissue trauma" -- I got that -- "later peroneal nerve palsy that caused

sustained efferent sympathetic nerve activity perpetuated in a reflex arc." Could you explain the last part of that sentence to me starting with the "efferent sympathetic nerve activity"?
A. Sure. What RSD is, it's kind of a dysfunction of the sympathetic nerves. These are the same sympathetic nerves responsible in a fight-or-flight-type response when people get scared or a predator type of thing, and what sympathetic nerves do is, they cause vaso constriction peripherally, which makes your skin cool, and it can also cause moisture changes because they're also responsible -- the nerve fibers are responsible for altering moisture

production.

So what the reflex arc is, the patient's ankle becomes painful. Then they use it less. And, also, the initial pain response causes sympathetic nerve activity to increase. The nerves become hypersensitive and then the patient basically keeps getting in this cycle where they have pain, they don't use their ankle, the sympathetic nerves keep firing.

So that's why one of the treatments is a sympathetic nerve block. But not all of -- when someone does a block in the lumbar spine, that doesn't hit all of the sympathetic fibers. Sometimes, there's

other sympathetic fibers which will not be addressed by the block. That's why lack of response to a nerve block doesn't mean that someone doesn't have RSD.

Q. And then you talk about various signs and symptoms of RSD. Did you see any of those signs or symptoms with Ms. Criswell?

A. She had four of them: Hypersensitivity to pain; she perceived normal touch as pain; she had skin-color changes -- I did not see that, but she had that documented previously -- and she did have joint stiffness. She also was noted to have osteopenia.

Q. Okay. So let's go over that.

The hypersensitivity, is that what she described to you when you saw her?

A. It is, and it's also -- it's also something you find on a physical exam. If you were to move somebody's ankle maximally, the normal person wouldn't scream. But if she screamed, that's hypersensitive.

Q. Did you do that?
A. Yeah. When I examined her ankle, she didn't scream, but she -- it appeared that she was quite uncomfortable, more than a normal person would be if you moved their ankle in that way.
Q. And did you note that in your records?
A. I don't think I did.

Q. So you just -- how do you know that that happened? You just remember that?
A. Yeah.
Q. So you have an independent recollection of her being hypersensitive when you moved her ankle?
A. Correct.
Q. Do you have an independent recollection as to when that happened?
A. Early in the visit and also later on when she resprained her ankle and I was examining her.
Q. So then when you first saw her three years after the incident in May of 2005, you're saying you noticed that --
A. She was a little bit difficult to examine because she was very sensitive about anybody touching her ankle and foot.
Q. Okay. But you didn't note that in the chart?
A. No, I did not.
Q. Okay. And now you're talking perception of normal touch with pain. Did you say she also had that, as well?
A. She had that, as well.
Q. And how do you know that?

A. Well, normally, if you just, like, stroke somebody's tendon, they shouldn't feel that that's

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causing severe pain.

Q. And did that occur with her?

A. She -- yeah. When I palpated her Achilles, she -- or not even palpated it. When I was just putting my fingers next to that area, she found it very uncomfortable.

Q. Okay. And, again, that's not noted in the chart?

A. No, it's not.

Q. You just remembered that?

A. Yes. I didn't focus on that because it wasn't something I was really -- I just considered it part of -- it was consistent with her previous diagnosis.

Q. And you have an independent recollection, back in May of '05, that that occurred?

A. Yes.

Q. And then changes in skin color, you're saying you didn't notice that?

A. I didn't notice any of that. But I wasn't looking either.

Q. How about moisture?

A. I did not check for that.

Q. Okay. Joint stiffness, you said you noticed that?

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A. Yes, I did notice that.

Q. And then the osteopenia, as we noted already, she had had that prior to August of '02; correct?

A. Correct.

Q. Okay. Then --

MR. LEVIN: Excuse me. What did you say, Doctor?

THE WITNESS: Correct.

Q. (By Ms. Massaro) Next, you indicate that, "Ms. Criswell cannot work on her feet for more than eight hours per day for three days per week."

You indicated, "on her feet." If she were working in a more sedentary position, would she be able to work longer hours?

A. Possibly, yes.

Q. And when you say, "possibly," what do you mean?

A. If it didn't aggravate something. It's hard to say because -- if we did something like what they call work hardening where you put her in that situation and see how she does -- because sometimes being in a dependent position where you're seated like that, your legs can swell, and that may aggravate RSD. So it's hard to say without initially putting her in that situation with physical therapy or a work-hardening

program.

Q. Okay. If she were in a position where she could keep her leg elevated, would that make a difference?

A. That would most likely help more than keeping them in a dependent position.

Q. And the eight hours per day for three days a week, is that so that she can have a day of rest in between each day? Is that the reason for that?

A. She basically said that, once she works three eight-hour shifts sequentially, she can't work on the next day because it's impossible for her to weight-bear because of pain on that fourth day.

Q. Okay. You're saying she works three days in a row?

A. I'm not sure what her schedule is because I never discussed that with her, but she told me she can't tolerate any more than three eight-hour shifts per week.

Q. Okay. But you just said, "sequentially," so that's what got me confused.

A. I think the worst -- yeah. I think the worst situation is, she told me she had to do that once and it was impossible. I'm not sure, if she spread it out, if that would be okay for her or not.

Q. Okay. So your opinion is that she, then, as far as -- if she was doing more sedentary work, she would be able to work more hours; is that correct?

A. Not necessarily. Just depending on whether that -- if it did not aggravate her RSD, if that solved the problem, then it would be okay.

Q. Okay. Have you seen her improve since you've been seeing her?

A. I've seen her improve, and then I've seen her get worse, and then slowly improve, recently.

Q. Sure. Did she get worse when she had the

accident again at another hospital the second time, the second accident that she had?

A. Yeah. She had a small setback at that point where she was decreased weight-bearing and decreased . . .

Q. So is that when she got worse, then?

A. Yes.

Q. After she experienced that trauma? Okay.

And then, on the last page, you say that the -- "Her injuries, as described above, are caused by trauma to the left leg and ankle."

Where on the left leg did she experience trauma other than the ankle?

A. Well, she said her -- what she told me is

that the machine struck her ankle. She had a laceration from that that healed. She also, at that time, fell over onto her knee.

Q. And is that what you based part of your opinion on, is the fact that she indicates she fell on her knee at the time of the incident?

A. No. I based it on the fact that, when I checked her during motion exercises with her weight-bearing, that she had palpable popping in between the tibia and fibula in her knee.

Q. Okay. And that is not based on the trauma that she alleges she had to the knee at the time of the incident?

A. Well, yeah, I believe it's from that, but, regardless of mechanism, without any prior history of trauma, that diagnosis makes sense to me.

Q. Okay.
A. That seems a sensible cause of her problem.
Q. So I'm still not clear, then. The trauma to the left leg, are you talking about the trauma to the knee?
A. Correct.
Q. Okay. And then you say, "and are permanent." And could you explain that to me?
A. Yes. Because of the instability of the knee,

the ligaments that are damaged, they're damaged. They're not going to heal back on their own at this point, and I think she'll just continue having that instability. The RSD has been going on now for the last five years, and that's not going to change. She also continues to have Achilles tendinitis. That's been going on five years. So I don't think any of these, really, are going to change at this point, five years from the initial injury.
Q. And as you said before, her RSD symptoms are controlled at this time with PT and medicine?
A. Yeah. They're managed, I think, is the correct term. They're not completely controlled because she still has symptoms despite the treatment.
Q. Okay. I'm going to ask you a few more questions, look at your curriculum vitae, and then I'm going to take a five-minute break and come back and complete everything. Okay?
A. Sure.
Q. But right now, let's take a look at Exhibit 1, which I believe is your curriculum vitae.

Take a look at that.

Do you have that in front of you?

A. Yes.

Q. Super. Is that -- there must be a date on

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it, actually, but is that -- can you tell by looking at it is that the most recent?

A. I think it's the most recent. The only thing I'm missing -- no. I think I have everything.

Q. So that does have everything. Okay.

How long have you been with Maricopa?

A. Well, I did my -- completed my residency there, so from 2000 to present minus two years.

Q. And where were you at those two years?

A. One, I was working for -- that was where I was when I did the initial blue chart for West Valley Orthopedics, and then I started --

Q. Okay.

A. And then one year was when I was a fellow -- doing a sports fellowship in San Diego with the Chargers.

Q. Is that mostly your practice, sports --

A. No. My practice is about 40 percent trauma, 40 percent sports, and about 20 percent other.

Q. And I take it, then -- have you ever been in private practice?

A. Yeah. That's where I was from 2003 to present.

Q. Okay. And the articles that you've written here, are any of those -- are any of the articles that

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are listed here, the six articles, or any articles that you have pending, related to the issues in this case?

A. No.

Q. I'm just interested for myself. You did some carotid artery thrombosis?

A. Sure.

Q. Why? Why did you do that? I'm just curious.

A. I was thinking of going into neurosurgery.

Q. I see. Okay.

A. That was as a medical student. And then I decided didn't like it.

Q. Okay. I notice you're also -- you have a license in California as well as Arizona?

A. Correct.

Q. Did you ever practice in California?

A. That was for my fellowship. It was required.

Q. Now, I just have a few questions.

Do you have any articles pending aside from what we have here?

A. No. Well, I do have one article pending, but that's not related to this case either.

Q. Okay. Have you ever lectured on the issues relevant to this case?

A. No.

Q. What society memberships do you have? AAOS?

That type of thing?

A. Yeah, American Academy of Orthopedic Surgeons. I think my induction is next January or March at the San Francisco meeting.

Q. Okay. Well, actually, what I need to know

is, what are you currently a member of? What societies are you currently a member of now?

A. None other than that and, I guess, the American Board of Orthopedic Surgery. I don't think that's a society though.

Q. No. And your specialties -- I think I asked you this before, but would you say that that's -- what would you say is your specialty?

A. Trauma surgery and sports. Sports is probably the specialty, and then trauma is what I do.

Q. Okay. That's the sense I got.

Okay. Are you board-certified?

A. Yes.

Q. When?

A. July 28th, 2006.

Q. And in orthopedics?

A. Orthopedic surgery.

Q. When you're in clinic -- you have clinic days and surgery days. How many patients do you see a day in clinic?

A. Clinic, 15 to 25.

Q. And where do you have privileges?

A. VA Hospital Phoenix, Maryvale Hospital, Maricopa Medical Center, Phoenix Memorial Hospital, West Valley Hospital, possibly Phoenix Baptist Hospital. I'm not sure.

Q. Okay. Can you tell me your week schedule? For example, Monday, you have surgery?

A. Monday is full-day clinic. Tuesday is usually elective surgery. Wednesday is morning clinic,

afternoon surgery. Thursday is morning clinic. Friday is all-day surgery.

Q. Have you ever had any staff privileges revoked or curtailed at any hospital?

A. No.

Q. How often do you perform legal review of cases?

A. Extremely rarely.

Q. Okay. In the past year -- actually, since you've been in practice, how many legal cases have you had other than the three that you've told me about in which you were the treating physician and it was, I assume, sort of like workers' compensation -- is that correct?

A. Yes.

Q. -- and, you said, state compensation.

Other than those three and this one, have you had any others?

A. I did one two weeks ago, and that's it.

Q. And in that one two weeks ago, were you deposed?

A. No. They wanted a summary of a patient's care, but it was someone that was in our hospital system. But the surgeon who was treating that patient is no longer with the hospital, so the attorneys asked me if I would do that for them even though I had never treated the patient before.

Q. I see. So you really weren't even a treating. You just did the summary, then, of what someone at your hospital had done?

A. Yes.
Q. Okay. So other than those three deps and this one, you've been at just four depositions now that you've participated in; is that correct?
A. Yes.
Q. And then --
A. That one was a written summary. I guess that's a deposition.
Q. No. Actually, the deposition refers to when you're actually under oath --

A. No. Then I didn't do that. That was just a written summary.
Q. But you have been deposed in the past?
A. Yes, for those workers'-comp-type hearings.
Q. Have you ever been involved in any trials?
A. No.
Q. So in all the cases that you've done, have you been representing the plaintiff or working with the plaintiffs, with the patients, I guess?
A. Yeah, with the patients.
Q. Do you advertise or anything --
A. No.
Q. -- for legal work?
A. No.
Q. I didn't think so.
Have you ever been sued?
A. No.
Q. Other than Arizona and California, are you licensed to practice in any other state?
A. No.

Q. Have you ever had your medical license suspended, revoked, or terminated --

A. No.

Q. -- in any state or any country?

A. No.

Q. I'm going to take a five-minute break and come back and then probably ask a few more questions and then we'll be done. Okay?

MR. LEVIN: I may have some questions.

MS. MASSARO: Sure. But I want to take five minutes and review what I haven't seen yet.

We can go off the record now.

(Recess.)

EXAMINATION

BY MR. LEVIN:

Q. Dr. Dewanjee, how are you?

A. Pretty good. I have a trauma, probably, to go to in about an hour or less.

MS. MASSARO: We're almost done.

Q. (By Mr. Levin) We'll be done.

Dr. Dewanjee, two follow-up questions: Getting back to your notes, you recommended her -- you recommended that she work, as tolerated, part time eight hours a day, three days a week as -- that was in your September 28, 2006, note; is that correct?

A. Correct.

Q. And, Doctor, in your January 29, 2007, note, she continued to follow your recommendation. She was working three eight-hour shifts; is that correct?

A. Correct.

Q. And, Doctor, as of May '06, you had her restricted to the work she could do on her feet; is that correct?

A. Yes.

Q. So, Doctor, when you write in your report that she was unable to work full time, that was based upon your review of your office notes; is that correct?

A. Yes.

Q. Doctor, when you saw her, you did note a few signs of RSD. Decreased touch, is that a sign of RSD you noted?

A. It can be depending on where it is.

Q. Did you note that in your record over the calf?

A. Yes.

Q. Is that consistent with the RSD that she -- is that consistent with the RSD which she's complaining about?

A. I can't make that conclusion. I'm not sure because it's in here medial calf. I would probably have to go back and exactly work out exactly which part of her calf it was and then look back at the nerve studies she had and all that.

Q. Okay. The stiffness of the ankle that you found, is that consistent with the RSD?

A. Yes.

Q. Doctor, it's your opinion, to a reasonable degree of medical certainty, that she developed RSD as

a result of the incident when she was run over by the X-ray machine; is that correct?

A. Correct.

Q. And, Doctor, you had reviewed records that indicated that she had RSD from other of her doctors; is that correct?

A. Correct.

Q. And --

A. Most notably the specialist from Johns Hopkins.

Q. And the specialist from Johns Hopkins made a diagnosis of RSD; is that correct?

A. Correct.

Q. And what did the specialist at Johns Hopkins base his diagnosis on?

A. I don't have his notes. I guess I'd have to look under --

MS. MASSARO: Exhibit 7. That's my Exhibit 7 if it's helpful.

THE WITNESS: I got it. Thank you.

So major findings, she had some tenderness, calf atrophy, weakness of the muscles. He noticed

hypersensitivity to touch, and dysesthesia, and numbness.

Q. (By Mr. Levin) Okay. Are those diagnostic of RSD?

A. They're part of the various findings in RSD. The dysesthesia is probably the most important one, and hypersensitivity.

Q. And, Doctor, also, Dr. DiPretoro, the

podiatrist, noted color changes?

A. That is another finding of RSD. That is an important one, as well, which was, I think, why she was admitted to the hospital, because of the color changes in her foot. They were worried that there was something else wrong with her, but they never found anything else.

Q. And, Doctor, bluish discoloration of the right foot, which was noted by Dr. Grabow, is that diagnostic of RSD?

A. That, in and of itself, is not, but it's part of the constellation of findings that is diagnostic of RSD. So when she was admitted to the hospital, they were trying to find the different causes of the bluish discoloration. They did an MRA to look at the arteries and veins, and they didn't find anything there. So after eliminating all their diagnoses in their

differential, the only thing they were left with was the RSD.

Q. And you agree with the diagnosis that she has RSD today; correct?

A. Yes. Yeah. There's nothing else I can find in the differential that would explain that constellation of findings.

Q. And, Doctor, you gave an opinion, to a reasonable degree of medical certainty, that the RSD is permanent; is that correct?

A. Yes.

Q. And what do you base your opinion on that the RSD is permanent?

A. The time from which she's had it and the natural history of RSD.

Q. Meaning what, Doctor?

A. Meaning that she's had this, now, for five years, and her symptoms have changed very little over the last couple of years. I doubt that anything is going to happen in the next couple of years or many years to make those change. I would have to defer to an RSD -- okay.

Q. And these symptoms, Doctor, have been documented by her medical providers for almost the past five years, have they not?

A. Correct.

Q. And the diagnosis of RSD, in fact, was made soon after the incident of May 2000, was it not?

A. Yes, within, I think, a month or two or three, somewhere in there. It doesn't develop immediately. It takes a little bit of time, typically.

Q. Doctor, you gave four medical conditions that she had as a result of this trauma: Number one, Achilles tendon partial tear; is that correct?

A. Correct. That's according to Dr. DiPretoro's note.

Q. And, Doctor, is it your opinion, to a reasonable degree of medical certainty, that the Achilles tendon partial tear was caused by the incident at Christiana Hospital when she was run over by the X-ray machine?

A. Yes.

Q. Doctor, the second injury that you believe is

caused by the incident at Christiana Hospital when she was run over by the X-ray machine is Achilles tenosynovitis; is that correct?

A. Correct.

Q. And, Doctor, it's your opinion, to a reasonable degree of medical certainty, that the Achilles tendinitis was caused by the trauma of being

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run over by the X-ray machine; is that correct?

A. Yes.

Q. And, Doctor, you gave an opinion today that the Achilles tendinitis is permanent; is that correct?

A. Yes.

Q. And, Doctor, what do you base your opinion on that the Achilles tendinitis is permanent?

A. She's had this for the last five years, approximately.

Q. And that has been recorded by her medical providers in the last five years of treatment; is that correct?

A. Correct.

Q. Now, Doctor, we talked about an injury to the peroneal nerve. Doctor, is it your opinion that that injury was a result of the serial casting that she had?

A. I'm not sure. I can't determine what that nerve injury is from.

Q. Doctor, would she have needed the casting if it wasn't for the ruptured tendon?

A. No.

Q. Doctor, to a reasonable degree of probability, is she a candidate for future surgery?

A. Yes.
Q. And why do you say that?

A. Because she has documented instability in her knee, and it's also consistent with MRI. She has a persistent Achilles tendinitis that's interfering with her ability to weight-bear on the foot.
Q. And would the goal of the surgery be, then, to resolve the Achilles tendinitis?
A. Yes, to resolve the pain in her ankle associated with weight-bearing activities.
Q. And, Doctor, if you could, in the Phoenix community, what would be the cost of the surgery?
A. Including hospitalization, associated therapy, surgical fees, medications, anywhere in the neighborhood of five- to twenty thousand per each surgery, of course.
Q. Doctor, Ms. Criswell gave you a history of the injury. Did she tell you that she was just tapped by the X-ray machine?
A. No.
Q. In fact, Doctor, the injury she sustained caused a laceration to her ankle; correct?
A. Correct.
Q. In fact, the X-ray machine caused a partial tear of the left Achilles tendon; is that correct?
A. Correct.
Q. And, Doctor, given that severity, would you

classify that as a tap?
A. No.

Q. Doctor, what does the Achilles tendon do?
A. The Achilles tendon's main job is to plantar flex the foot in the push-off phase of gait.
Q. And, Doctor, she has complained that she is unable to stand on her feet for more than eight hours at a time. What is the mechanism -- or which injury is causing that condition?
A. The combination of RSD and chronic Achilles tendinitis.
Q. Doctor, your records indicate that she was wearing a cam walker?
A. She may have had that at some point. I can't recall when I made that statement.
Q. It's on the September 28th, '06, note.
Doctor, my question to you is: What is a cam walker?
A. A cam walker is a brace, essentially, for the ankle. It's a large, black boot that prevents someone from moving their ankle, to hold it still to let the swelling, inflammation, and pain slowly resolve as best possible.
Q. And for what condition would the cam walker be used to stabilize the ankle?

A. Ankle sprain.
Q. I'm saying would it be used for the ankle tendinitis or the RSD?
A. It could be used for any of those.
Q. I see.
Doctor, I think that's all the questions I have for you right now. I may have others after

Counsel.

EXAMINATION

BY MS. MASSARO:

Q. Okay. I just have a few, not many. I promise that we will get you out of here in time.

A. Okay. Thank you.

Q. Okay. I just wanted you to take a quick look at your -- well, actually, my exhibit. And I specifically do want you to look at my exhibit because there's something I wanted to point out. If you'll look at my Exhibit No. -- the one that is -- are your records, which would be --

A. 5?

Q. Yes.

If you could look at -- Counsel just pointed out to you that, on September 28, 2006, and on January 29, 2007, it indicates that the patient could work three eight-hour shifts per day.

If you could look at the top of those two, it says -- you see a fax line? What is the date on that fax line?

A. November 20th, 2006.

Q. I'm talking about my exhibit. Because this is the date that I received these records. Are you looking at my exhibit?

A. Yes.

Q. Exhibit No. 5? Because I did not receive those until March 27th. I'm looking at my Exhibit 5 with your records.

A. You mean the note dated Monday, September 26,

2005?

Q. No. Thursday September 28th, 2006, and also January 29th, 2007. They're at the end of your exhibits. If you look at the fax line at the top . . .

MR. LEVIN: Which note?

MS. MASSARO: September 28, 2006, was the date on the fax line, in the left-hand corner.

Q. (By Ms. Massaro) Are you at that page?

A. Yes.

Q. Do you see, on the top line, where it says -- the fax line?

A. Uh-huh.

Q. -- at the very top?

What is the date on that?

A. I think it says March 27th, 2007.

Q. How about the next page, Monday, January 29th, 2007? What does the fax line say?

A. March 23rd, 2007.

Q. Okay. Great.

That's all on that. Thank you.

My exhibit -- go ahead and keep that in front of you. I'm going to ask you a few more questions.

My Exhibit No. 6, this is -- go to the second page of No. 6. You'll see that this is the Employee Health Record where Ms. Criswell reported to employee health.

Let me just ask you. Do you see any complaints of knee pain? I'm talking about dated -- there's two of them. One's dated 5-28-02 and one is dated 5-23-02. You can look at both of those and let

me know if you see anything about knee pain.

A. The only thing I see is, on the second page, Employee Health Service Referral, under "A," I don't know if it says, "Trauma, left knee/Achilles," or what it says.

Q. Where are you at?

A. It's the --

Q. What date? Tell me what date.

A. The date, 5-23-02.

Q. Okay. And then under "A"?

A. Yes, in the handwritten part in the box at the bottom.

Q. What is the title in the box?

A. Well, I guess it's called Section 2, "To be completed by physician and/or nurse."

Q. Okay. Got it. Got it. I'm looking in the wrong Section A, because I'm not looking where you're looking at. Okay.

It says, "Trauma, left heel, Achilles"?

A. Yeah. I don't know if it says heel or knee. I really don't know.

Q. Well, if you'll notice, in that same question, in the upper left-hand corner, there's pictures of two bodies. What section is circled on that?

A. That's the chief complaint, and it's circled the worst pain is a number seven, and she puts that in the ankle.

Q. Okay. Do you see a knee circled at all there?

A. Well, it's the chief complaint, so they'd only put one circle.

Q. Okay. Let me ask you to look at Section O.

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And it says -- in the second line, it says, "posterior heel."

Does that word look like the same "heel" in "A," under "assessment"?

A. It does to me, kind of.

Q. Look at Exhibit No. 10, my Exhibit No. 10. And this is an MRI of the left ankle that was done on June 1st of '02. Could you read the conclusion of that MRI at the bottom of the page?

A. "No evidence of Achilles tendon rupture or complete tear. Findings compatible with distal Achilles tendinopathy.

Q. Now, you believe that Ms. Criswell has RSD; correct?

A. Correct.

Q. And how long have you been treating RSD patients?

A. I don't typically treat RSD patients. I base that conclusion upon a previous diagnose from Hopkins.

Q. Okay. And you say that you would do Achilles tendinitis surgery on a patient with RSD; is that what you're saying?

A. No. I would refer her to a foot and ankle subspecialist to determine whether he thought -- he or she thought that Ms. Criswell would benefit from that.

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Q. Well, then, how come, a moment ago, when Plaintiff's counsel asked you if you believe, to a reasonable degree of medical probability, that she would need this surgery in the future, you said, "Yes"?

A. Well, just because I think she needs the surgery doesn't mean I'm going to do.

Q. Okay. But you think that she should have this surgery even though she has RSD? You would recommend this surgery --

A. Well, it depends on how much of the proportion of her symptoms come from her Achilles versus her RSD. Sometimes, RSD can flare up. Sometimes, it can remit. It just depends on what proportion of symptoms it's contributed to her ankle problem.

Q. But for purposes of this lawsuit, you were specifically asked would you recommend -- do you believe that this surgery is medically necessary to a reasonable degree of medical probability. That's the question.

A. That's impossible to answer in some ways without additional information.

Q. Okay. And what additional information would you need to make that assessment?

A. I would need to know from her, the patient,

how bad her symptoms are now and whether she wants to be willing -- she wants the risk of having other additional problems versus an option to cure her ankle. Because every surgery has complications associated with it, and she may not be ready to accept those

complications.

Q. Okay. But as far as her symptoms now, then, you know -- do you know her condition now, what her condition is now?

A. Yes.

Q. Would you recommend the surgery now?

A. Only if she's willing to accept the risk that goes along with the surgery.

Q. Has she indicated to you that she is?

A. No, she is not ready at this point. She's apprehensive about having surgery.

Q. Has she indicated to you that she does not want the surgery?

A. No.

Q. Okay.

A. She has indicated she doesn't want surgery on her knee at this point.

Q. Okay. But she hasn't indicated to you that she doesn't want surgery on the Achilles tendon?

A. She hasn't indicated, to me, that one way or

the other at this point.

Q. Have you ever discussed it with her?

A. Yes.

Q. And what date did you discuss that with her?

A. I'm not sure. It was -- I think, when she first saw me, she was addressing her knee, so we worked that up for quite a bit. And then, later on, she reinjured her ankle, so we were trying to get her through the RSD flare-up from the ankle sprain.

Q. Did you make any notation of your discussion

Q. Okay. But yet the ankle sprain is what you're alleging caused the problem with her knees; is that correct?

A. The ankle sprain caused the problem with the knee, but the Achilles injury was a result of a direct blow from the laceration and the trauma.

So two different things happened in that injury. The first one was direct trauma of an object hitting the back of her ankle, which apparently damaged part of her tendon and cut her skin. At the same time,

she twisted her ankle, which sprained the ligaments, and that's what caused the problem with the knee.

Q. Okay. Now, you noted in your report, in your first report, that -- on the first page, that she had a superficial laceration. Is that -- did you ever see the laceration that occurred three years before you --

A. No, I had never seen it.

Q. Did you see any scarring or disfigurement as a result of the laceration?

A. She may have had a small scar, but it wasn't significant enough to me that I put it in my notes.

Q. So the doctor who saw her did note it as a superficial laceration; is that correct?

A. Yes.

Q. I'm sorry. I didn't hear you.

A. Yes, that is correct.

Q. Okay. Just about done. Never trust a lawyer when they say they're almost done, but I am almost done.

Can you say that, but for the incident at

Dewanjee
Christiana Hospital, Ms. Criswell would not have developed RSD?
A. Yes.
Q. And why is that?
A. Barring any other trauma to her ankle,

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there's no reason to have RSD just spontaneously occur.
Q. Okay. Can you say that, but for the incident at Christiana Hospital, she would not have developed Achilles tenosynovitis?
A. That is not a hundred-percent accurate. It is possible to get Achilles tendinitis with -- if you're a basketball player or something like that where you do a lot of jumping sports.
Q. Would you say that, but for the incident at Christiana Hospital, she would not have developed the Achilles -- partial Achilles tendon tear?
A. Yes. That's from the trauma.
Q. Have you expressed all the opinions that you will testify to at trial regarding Ms. Criswell's medical issues?
A. Yes.
Q. Is there any further material that you need to form an opinion? And, if so, what?
A. Just Ms. Criswell's opinion on her surgeries, whether she believes, at this point, she's ready to have that; which problem is bothering her more, her ankle or her knee at this point.
Q. Okay. Is there anything else you expect to do in connection with this case before trial in a month?

A. No. I do not expect to do anything else.
Q. Have you, here today, expressed all of the opinions that you will testify to at trial regarding Ms. Criswell and the injuries she allegedly sustained as a result of the May 23rd, 2002, incident at Christiana Hospital?
A. Yes.
Q. I have no further questions.

EXAMINATION

BY MR. LEVIN:

Q. Just a couple, Doctor.

The Achilles tendinitis, is that -- Doctor, do you have an opinion, to a reasonable degree of medical certainty, whether or not the Achilles tendinitis was caused by the X-ray machine running over the back of her ankle at Christiana Hospital?
A. Yes, that was caused by --
Q. What is your opinion? What is it?
A. The cause of her tendinitis was the partial tear and the trauma.
Q. And, Doctor, earlier, you said, in questioning, that if she was a basketball player, she may have developed tendinitis. You have nothing in the history that she was having any repetitive, up-and-down stress to the tendon; is that correct?

A. No. What I meant to say was that, if she didn't get hurt at the hospital, if she were to go on and play basketball or do something, it is possible that that could give you a tendinitis.

CERTIFICATE OF REPORTER

STATE OF ARIZONA)
) ss:
COUNTY OF MARICOPA)

I, MICHAEL H. DIPPEL, a certified reporter, do hereby certify that the foregoing deposition was taken before me in the County of Maricopa, State of Arizona; that the witness, before testifying, was duly sworn by me to tell the whole truth; that the questions propounded to the witness and the answers of the witness thereto were taken down by me in shorthand and thereafter reduced to typewriting; that the foregoing pages, numbered 1 through 104, inclusive, constitute a true and accurate transcript of all the proceedings had upon the taking of said deposition, all done to the best of my skill and ability; and that pursuant to Rule 30(e), Arizona Rules of Civil Procedure:

Upon request, the witness or his/her attorney was notified that the transcript was available for review and signature.

I FURTHER CERTIFY that I am in no way related to any of the parties nor am I in any way interested in

Dewanjee

the outcome hereof.

IN WITNESS WHEREOF, I have set my hand in my office in the County of Maricopa, State of Arizona, this 29th day of March, 2007.

MICHAEL H. DIPPEL, RPR, CR NO. 50716

EXHIBIT B

EXHIBIT 1

Sumit Dewanjee, MD

OFFICE ADDRESS
Maricopa Health System
Department of Orthopaedics
2601 E. Roosevelt St.
Phoenix, AZ 85008

E-MAIL
onepoint1@att.net

VOICE MAIL/CELL
602 540 7512

PERSONAL ADDRESS
7301 E 3rd Ave #413
Scottsdale, AZ 85251

EDUCATION & TRAINING

Cornell University, Ithaca NY
Undergraduate, Anatomy and Physiology Major, Philosophy Minor

University of Miami School of Medicine, Miami, FL
Medical School, MD, May 8, 1998

Southern Illinois University School of Med. Orthopaedic Residency, Springfield, IL
Orthopaedic Surgery Resident, July 1, 1998 – June 30, 2000

Phoenix Orthopaedic Residency Program, Phoenix, AZ
Orthopaedic Surgery Resident, July 1, 2000 – June 30, 2003

OASIS Sports Fellowship, San Diego, CA
Orthopaedic Sports Surgery Fellow, completed July 31, 2004
assistant team physician for San Diego Chargers, OMBAC Rugby, Riptide Arena Football, USD Soccer and Basketball, Point Loma N. University, multiple local high school football teams in San Diego County

RESEARCH ACTIVITY

1. "Effectiveness of Donor Site Grafting in Preventing Patella Infera Following Patellar Tendon Harvesting in a Rabbit Model." Selected for *Housestaff Achievement Grant*, MIHS, 2001.
2. "Semitendinosus Allograft in Coracoclavicular Reconstruction following Acromioclavicular Dislocations." Ongoing research, MIHS, Phoenix, Arizona
3. "Widespread hemodynamic depression and focal platelet accumulation after fluid percussion brain injury: a double-label autoradiographic study in rats." *Journal of Cerebral Blood Flow and Metabolism*, May 1996, pp. 481-489.
4. "Acadesine Reduces Indium-Labeled Platelet Deposition After Photothrombosis of the Common Carotid Artery in Rats." *Stroke*, January 1995, Vol. 26, pp. 111-116.
5. "Transient Platelet Accumulation in the Rat Brain After Common Carotid Artery Thrombosis: An In-111 Platelet Study." *Stroke*, October 1993, Vol. 24, pp. 1534-1539.
6. "Distribution of Indium-111 Labeled Platelet Emboli in the Rat Brain Following Common Carotid Artery Thrombosis." *University of Miami School of Medicine Summer Student Poster Presentation*, August 1992.

HONORS & AWARDS

July 2003	Silver Award for performance in Musculoskeletal Anatomy of upper & lower extremity
December 2001	Silver Award for performance in Musculoskeletal Anatomy of lower extremity
December 2002	Gold Award for performance in Musculoskeletal Anatomy of upper extremity Phoenix Orthopaedic Residency Training Program
August 2001	MIHS Residency **Housestaff Achievement Grant** recipient
July 1997	**Honors** for performance on USMLE Step 1, University of Miami School of Medicine
Summer 1995	**Summer Research Fellow Award**, University of Miami School of Medicine. Grant for study of cerebral reperfusion injury.
Summer 1992	**Outstanding Research Project Award**, University of Miami School of Medicine, *Summer Student Research Poster Session*, Miami, Florida.
Spring 1989	**National Merit Finalist**, Miami Palmetto Senior High School

WORK EXPERIENCE

Assistant Team Physician for: Fall 2000, 2001,2002
Arizona Thunder Pro Soccer Team, Carl Hayden Varsity Football Team,
Central High School Varsity Football Team. Phoenix, Arizona.

Personal Trainer, Pure Fitness Gyms Fall 2000 - 2001

Teaching Assistant, Gross Anatomy, September 1997
University of Miami School of Medicine
Tutored medical students in anatomy of the back and extremities.

Volunteer Preceptor, Clinical Skills, September 1997
University of Miami School of Medicine
Tutored medical students in obtaining patient history and performing physical examination

Clinical Assistant, Department of Orthopaedic Surgery, Summer 1995
University of Miami School of Medicine, Division of Joint Replacement
Completed initial patient interviews, completed post-operative assessments.

Research Assistant, Department of Neurology, Div. of Research Summer 1993 -
Studied effects of brain trauma on cerebral blood flow and thrombosis Fall 1994
in a rat model.

Research Associate, Department of Neurology, Div. of Research Summer 1992
Localized regions of brain susceptible to embolic stroke in a rat model.

VHS Outpatient Clinics, Phoenix, AZ August 2004 -
Staff orthopaedic sugeon, Abrazo Healthcare System August 2006

MedPro, Phoenix, AZ July 2005 -
Staff orthopaedic surgeon present

EXTRACURRICULAR ACTIVITIES/ HOBBIES

1976 – present **Classical and Contemporary Piano, Alpine skiing, Windsurfing, Target Practice**

1994 – 1995 **Dean's Cup Athletic Competition.** 2nd in 200m and 400m dash events in annual competition between University of Miami Schools of Medicine & Law

1996 – 1997 **Eastern Student Research Forum Committee.** Organized annual oral and poster sessions for medical and graduate students in the Eastern U.S.

Spring 1995 **Florida Keys Health Fair.** Participated in community outreach project
Spring 1997 to provided health care to underserved populations in the Florida Keys.

1991 – '93 **Intercollegiate Rugby Club, Cornell University**

2005 – present Active member of American MENSA, Ltd.

BACKGROUND

Languages spoken:	English, Spanish, Bengali	
Place of Birth:	Boston, MA	
Primary School:	Herbert Hoover Elementary School	Rochester, MN
	John Adams Junior High School	Rochester, MN
Secondary School:	John Marshall Senior High School	Rochester, MN
	Miami Palmetto Senior High School	Miami, FL

STANDARDIZED TEST RESULTS AND PROFESSIONAL LICENSURE

American Board of Orthopaedic Surgery Certified as of July 28, 2006

USMLE Step I:	227,pass	MCAT: Physical Sciences		11
Step II:	224,pass	Biological Sciences		11
Step III:	208,pass	Reading Comprehension		11
SAT Mathematics:	750	**AZ Medical License #32018 (current)**		
Verbal reasoning:	700	**CA Medical License #A 82775 (current)**		

EXHIBIT 2

SUMIT DEWANJEE, M.D.
LEGAL FEE SCHEDULE

ALL FEES ARE TO BE PRE-PAID 14 DAYS IN ADVANCE

Conferences: (Telephone or in person)	$400.00/hr Minimum $200.00/30 minutes
*After hours; i.e. evenings/weekends	$500.00/hr Minimum $250.00/30minutes
Depositions: *After hours; i.e. evenings/weekends/or outside location	$650.00/hour*Min 1 hr
Video Depositions: After hours; i.e. evenings/weekends/or outside location	$ 850.00/hour**/Min 1 hr $1,000.00/hour*Min 1 hr
Arbitration Hearings:	$ 650.00/hour**+travel time (Travel time is 1 hr of time allowing for time out of office & actual travel of $350.00/hr)
Trial Appearance:	$2,600.00/half day** Plus travel expense
Records Review without report: With report (includes $50.00 Transcription Fee)	$ 350.00/hr (pro-rated) $ 500.00
IME: (includes $50.00 Transcription Fee) (Includes 1 hour records review) Patient examination with report on causation, Impairment. Additional record review (over 1 hr billed at $350.00/hr) All records must be received in our office one-week before scheduled IME.	$ 700.00/IME**
Narratives: (includes $50.00 Transcription Fee)	$ 500.00
Impairment Ratings (forms only)	$ 100.00/page
Impairment Ratings (Exam by Treating Physician) (Includes $50.00 Transcription Fee)	$1,000.00
Impairment Rating (Exam by Nontreating Physician) (Includes $50.00 Transcription Fee)	$2,000.00

****CANCELLATION POLICY****

Conferences 72 hour or more notice for refund.

Depositions & Arbitration Hearings: 5 working day notice for refund

Trial Appearance: 11 or more working days notice, $550.00 scheduling fee withheld
8-10 working days notice, ½ of fee retained + $550.00 scheduling fee
7 or less working days notice no refund of fees.

IME: 5 working days no refund
6 or more working days refund of ½ fees ($350.00).

Revised 2/27/07